**EXHIBIT B**

**DOCUMENTS TO BE PRODUCED IN RESPONSE TO SUBPEONA SERVED BY REVOLUTION MONITORING (et al)**

This Subpoena seeks Protected Health Information under the Health Insurance Portability and Accountability Act of 1996, Pub.L. No. 104-191, §264, 110 Stat. 1936 ("HIPAA"). More specifically, this Subpoena requests documents that are exclusively related to the Patient Claims shown on the attached "Patient & Claim Listing" and only for the period of time beginning seven days before the date of service (DOS) shown for each Patient Claim, until the date of this Subpoena, and only related to the medical services provided to the Patient and billed by: Revolution Monitoring NPI: 1235541509 TIN: 46-5128843; Revolution Neuromonitoring NPI: 1861871402 TIN: 47-3421017; Revolution Monitoring Management NPI: 121538965 TIN: 81-3155319 (collectively referenced herein as "Revolution Monitoring").

The term "Covered Entities" means a health plan, a healthcare clearinghouse, or a healthcare provider who transmit any health information in an electronic form, and includes "any person who…comes into possession of protected health information." Tex. Health & Safety Code 181.001(b)(2). Under 45 C.F.R. 164.512 "covered entities" are authorized to disclose "protected health information" without written authorization of the individual under 45 C.F.R. 164.508, or the individual being given the opportunity to agree or object under 45 C.F.R. 164.510 in judicial or administrative proceedings in compliance with 45 C.F.R. 164.512(e).

For all document requests herein, refer to the attached "Patient & Claim Listing" for the Patient Identifier as generated from the USMON system, (the "PID"), date of service (DOS), claim number, policy number, and billed amount for Patient Services Rendered by Revolution Monitoring et al individually each Patient Claim in the Patient and Claim Listing, is labeled herein as a "Patient Claim."

You are instructed to label each document you provide in response to this Subpoena with the Patient Identifier (PID) or Policy Number.

**ATTACHMENT 1**

**DOCUMENT REQUESTS**

**A. Produce the following documents related to each and every Patient Claim represented in the attached "Patient & Claim Listing" shown on Exhibit B as follows:**

1. The Insurance Policy, including but not limited to (a) the governing Master Plan Documents, and (b) any material modifications and amendments to the Insurance Policy or Plan;
2. The summary of the Insurance Policy, including plan benefits or coverage provided to Patients covered by the insurance Plan (the summary of policy document may be identified as the Summary of Benefits & Coverage (SBC); the Summary Plan Documents (SPD) or another acronym.
3. The Explanation of Benefits (EOB).
4. Documents specifically identifying and describing the adjustment reason relied upon in the EOB, including but not limited to the Policies and practices, or the application thereof, relating to your decision regarding payment, non-payment, and denial, of each of the claims shown in the "Patient & Claim Listing."
5. All responses to appeals and any other documents referring or relating to each such appeal, including claims policy manuals or other claims processing guideline documents identifying and describing the reasons relied upon in the response to the appeals, or the application thereof, and any emails or memos regarding same, for each of the claims shown in the "Patient & Claim Listing."
6. The "Legislative Fee Schedule" or "Legislative Contracted" adjustment explanation, definition, and policy provisions as related to the billing by Revolution Monitoring on the Patient Claims.

**B. Produce documents and reports of the Electronic Funds Transfer (EFT) /(EDI) Transaction Records and related and supporting documents for the identified Patient Claims shown in the "Patient & Claim Listing" including but not limited to:**

1. Insurer's definition and or explanation of all claims adjustment reason codes (the "CARC") utilized in its electronic remittance advice (the "ERA").
2. All adjustments codes utilized by the insurer other than the standardized CARC,

which may also be identified as remittance advice remark codes (the "RARC") or may also be identified as Group Codes, if utilized in any documents produced herein.

3. The HIPAA required Electronic Data Interchange policy, procedure and work instructions manual(s), including but not limited to those covering Standard Transactions.
4. Policies procedures and methodologies (with specificity) for conducting Standard Transactions.
5. For Patient Claims that were sent to third party repricing entities, provide all documents, communications, third party fee schedules, and repricing methodology used or applied to any Patient Claim.
6. All Administrative Services Only or Administrative Services Agreement(s) ("ASO / ASA") including but not limited to
    a. Standard schedule of fees for administrative services provided;
    b. Recovery or recoupment fees; and
    c. Negotiated Discount Fees.
7. Any and all Policy, Procedure and Work instructions for claims handling.
8. All policies and procedures related to Administrative Simplification.
9. All policies and procedures related to Implementation Specifications.
10. All claims which could not be entered into the claims handling system.

**C. Produce data (in standardized EDI ANSI x12 v5010 format) and any related reports, in their required statutory and regulatory native format(s), for the Electronic Funds Transfer (EFT) Transaction Records for the Patient Claims shown in the "Patient & Claim Listing" as follows:**

1. All ANSI X 12 837 (Healthcare Claim) (showing billed charges, amount paid, and to whom).
2. All ANSI X12 277 (Claims Status)
3. ASC X12 277CA 5010 format [Health Care Claim Acknowledgement, including TRN Reassociation Trace Number data segment necessary for reassociation showing whether the claim was accepted, and the designated assignee and/or payee.
4. ASC X12 275 5010 format Additional Information to Support a Health Care Claim or Encounter.
5. All ANSI X12 835 (Electronic Remittance Advice or ERA) with the provider.

6. All Continuity of Care Document (CCD) + addenda (on every claim with the receiving bank in ACH File).
7. All originating bank information (ODFI) on every claim processed.
8. All (HIPAA mandated) transaction ID's from the originating bank identifying each claim processed.
9. All Clearinghouse transactions for each claim processed.
10. Reference information related to all transactions by "Repricers", "Negotiators" or "Cost Containment" vendors contracted by the Insurance Provider or Third Party Administrator (TPA) for ALL transactions submitted [Including Identities of Vendors, Reports and Invoices].
11. The Patient Claim "reassociation" and trace information from the Plan/Payor: which identifies, tracks and confirms the entity to whom the payment was made.
12. Identification of any "Overpayment Offsets", "Recoveries" or "Withholding" done in association with any of the claims identified in the "Patient & Claim Listing".

**ATTACHMENT 2**

**Patient & Claim Listing**

Each subpoena will include a detailed and unique list of patient information for each claim that Revolution Monitoring billed each Covered Entity. The patient information will include:

> Patients First Initial, Last Name; Date of Birth; Patient ID (PID); Policy Number; and Date of Service(s).